IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF NORTH CAROLINA

MAXWELL KADEL, *et al.*,

Plaintiffs,

v.

No. 1:19-cv-272-LCB

DALE FOLWELL, in his official capacity as State Treasurer of North Carolina; **DEE JONES,** in her official capacity as Executive Administrator of the North Carolina State Health Plan for Teachers and State Employees; **NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES**; and **STATE OF NORTH CAROLINA, DEPARTMENT OF PUBLIC SAFETY,**

Defendants.

DECLARATION OF BLUE CROSS BLUE SHIELD OF NORTH CAROLINA

I, AIMEE FOREHAND, on behalf of Blue Cross and Blue Shield of North Carolina ("BCBSNC"), state that to the best of my knowledge and based on a review of BCBSNC's records, the following is true and accurate:

1. BCBSNC is a non-profit medical services corporation, which is organized and existing under the laws of the State of North Carolina. BCBSNC is headquartered in Durham, North Carolina.

2. BCBSNC is the Third-Party Administrator ("TPA") of the North Carolina State Health Plan for Teacher and State Employees (the "State Health Plan" or the "Plan").

3. The State Health Plan is a self-funded customer of BCBSNC, which means that, in addition to deciding what benefits the Plan will provide to Plan participants each year, the Plan is also solely responsible for paying for all the benefits it has agreed to provide.

4. As TPA for the Plan, BCBSNC has a contract with the Plan to provide administrative services on behalf of the Plan. More specifically, after a participating, in-network healthcare provider provides a medical service to a Plan participant, the medical provider submits a claim to BCBSNC which processes the claim according to the terms of Plan and determines the amount of reimbursement that the healthcare provider will receive by the Plan for that service based on the terms of the Plan and the network participation agreement between BCBSNC and the participating provider.

5. The contract between the Plan and BCBSNC is an Administrative Services Only (hereafter "ASO") contract, which means that BCBSNC provides only administrative services that relate to the processing of the claims. BCBSNC has provided these services to the Plan for more than 30 years.

6. In addition to serving as a TPA for the Plan and other customers, BCBSNC also sells private health insurance to groups and individuals. BCBSNC uses its claims processing system and standards in the same manner for both its private health insurance business and its work as the TPA for the Plan. In both

circumstances, the BCBSNC operates in the manner accepted as the industry standard for the provision of healthcare benefits.

7. In accordance with industry practice, BCBSNC uses industry-standard procedural codes and diagnostic codes to determine whether a claim submitted to it by a healthcare provider for a specific medical treatment is compensable by the Plan. These diagnostic and procedural codes are not created by BCBSNC, but are uniform across the American health care, health benefits plan, and health insurance industries. Diagnostic codes are classification of diseases as provided by the ICD ("International Classification of Diseases"). Medical services and procedures are identified by a distinctive alphanumeric code known as CPT code ("Current Procedural Terminology"). Every medical service has its own unique CPT Code.

8. In order to request reimbursement for the medical service provided to a Plan participant, an in-network health care provider submits a claim to BCBSNC on an established industry form (either a CMS-1500 or UB-04 form depending on the type of provider; copies attached) or through an electronic billing agreement which requires the same information.

9. To receive reimbursement, a healthcare provider must submit a claim that contains both a diagnostic code and a corresponding procedural code (or, for facilities, a revenue code rather than a procedural code), among other information. This is the standard requirement across the national health insurance industry. Failure to submit both a diagnostic code and a corresponding procedural code results in denial of the claim.

10. When BCBSNC receives a claim for reimbursement from a provider, BCBSNC's automated claims systems reviews the claim to determine whether it is for a benefit covered by the Plan. If the medical treatment is a covered treatment, BCBSNC authorizes reimbursement to the healthcare provider by the Plan.

11. Each year, the State Health Plan creates a benefits booklet, which describes the benefits and reimbursement levels offered to eligible Plan participants. As TPA, BCBSNC receives and reviews the final Plan benefit booklet each year. BCBSNC is responsible for implementation of the benefits outlined in the benefit booklet. Because the benefits booklet does not contain or identify either procedural or diagnostic codes, BCBSNC—in consultation with the Plan staff—implements the coding for the benefits covered by the Plan.

12. When a healthcare provider performs a service for a Plan participant, the provider submits a claim to BCBSNC for reimbursement (as a benefit provided by the Plan). For more than 90% of claims submitted to BCBSNC for Plan beneficiaries, the process is automated, meaning it is processed electronically without being separately reviewed by a person.

13. As part of the claim submission, BCBSNC receives the name of the Plan participant, the name of the healthcare provider, the age and sex of the Plan participant, the ICD diagnostic code, and the CPT procedural Code, among other information. This is the industry-standard information required for claims submitted to insurance providers for reimbursement of expenses for medical services, and this information is submitted by the physician or other healthcare provider where the

physician or healthcare provider is a participating, in-network provider. BCBSNC has a publicly available manual for healthcare providers that advises them on what information must accompany a claim, and how to properly submit a claim.

14. As part of the claim submission process, BCBSNC does not request or require that the healthcare provider identify the transgender status of any person seeking medical care. The BCBSNC claim submission process does not include any method for the healthcare provider to submit this information, and the transgender status of any person is not recorded within the BCBSNC databases.

15. Certain claims require approval by BCBSNC before the medical service is provided to the Plan participant. BCBSNC and the State Health Plan jointly decide which claims will be subject to this preauthorization requirement. All inpatient surgical procedures require preauthorization. There is no separate or unique preauthorization requirement for claims submitted on behalf of individuals who identify as transgender.

16. Further, in determining whether to approve or deny a claim, BCBSNC does not consider whether the Plan participant identifies as transgender. More specifically, BCBSNC does not track whether any specific Plan participant identifies as transgender, cisgender, gender non-binary, etc. Thus, the transgender status of any person—or whether any person identifies as transgender—is not a fact that BCBSNC uses at any time to determine whether BCBSNC will approve a claim for benefits for State Health Plan participants.

17. BCBSNC processes claims for medical services provided to an individual who identifies as transgender in the exact same manner as BCBSNC processes claims for medical services provided to an individual who does not identify as transgender. BCBSNC process claims for medical services for gender non-binary individuals in the exact same manner as BCBSNC processes claims for medical services for an individual who identifies as neither transgender nor gender non-binary.

18. As noted above, in excess of 90% of submitted claims are approved by BCBSNC's claims-processing software. Claims not approved in this fashion because, for example, the software has identified a potential duplicate bill, are manually processed by BCBSNC employees. After this employee review, claims are approved or denied. Reasons to deny a claim include: incorrect coding (diagnosis or procedure), duplicative billing, failure to obtain prior authorization when required, or other reasons.

19. BCBSNC will not approve a claim, or preauthorization, for a service not covered by the Plan.

20. To the best of my knowledge, prior to January 1, 2017, in its implementation of the Plan Benefit Booklet, BCBSNC denied preauthorization for 4 specific surgeries, regardless of the diagnostic code.

Table 1

CPT Code	Description of Surgery
55970	Intersex Surgery, Male to Female
55980	Intersex Surgery, Female to Male

57335	Vaginoplasty for Intersex State
56805	Clitoroplasty for Intersex State

21. To best of my knowledge, prior to January 1, 2017, BCBSNC either denied preauthorization or reimbursement for claims for the following procedures when the procedural code is for treatment of one of two diagnostic codes: F64.0 (Transsexualism) or Z87.890 (Personal history of sex reassignment):

Table 2

CPT Code	Description of Surgery
54400	Insertion of Penile Prosthesis; non-inflatable (semi-rigid)
C1813	Prosthesis, Penile, Inflatable
54401	Insertion of Penile Prosthesis; inflatable (self-contained)
54405	Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54406	Removal of multi-component Inflatable Penile
54408	Repair Components(s) multi-component, Inflatable Penile
54410	Removal and replacement of all components(s) of a multi-component, inflatable penile prosthesis at the same operative session
54411	Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54415	Removal non-inflatable (semi-rigid) /inflatable
54416	Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis at the same operative session
54417	Removal and replacement of a non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue
54660	Insertion of Testicular Prosthesis (separate procedure)
55175	Scrotoplasty (simple)
55180	Scrotoplasty (complicated)
56800	Plastic Repair of Introitus
57291	Construction of artificial vagina (without graft)
57292	Construction of artificial vagina (with graft)
19316	Mastopexy
19318	Breast Reduction
57295	Revision (including removal) of prosthetic vaginal graft

57296	Revision (including removal) of prosthetic vagina graft
19325	Breast Augmentation with implant
17380	Electrolysis Epilation, each .5 hour

22. Although the industry-standard medical claim form requires a healthcare provider to identify the sex of the Plan participant, BCBSNC does not use the sex of the Plan participant to evaluate whether claims for the benefits identified above are covered by the Plan. This is true whether the claim is processed automatically or manually. Approval or denial of a claim is based solely on the procedural and diagnostic codes identified above.

23. Beginning on January 1, 2017, the Plan directed BCBSNC to approve claims when submitted with the procedures listed in Table 1—without regard to the diagnostic code—and in Table 2, when submitted with the two identified diagnostic codes.

24. Beginning on January 1, 2018, at the direction of the Plan, BCBSNC returned to its 1990-2016 claims processing rules, and thereafter denied claims for the above-referenced procedures because they were not included as benefits provided by the Plan.

25. BCBSNC would not approve a claim for cosmetic procedures for any Plan participant, regardless of the diagnostic code. The State Health Plan benefit booklet defines cosmetic services as not covered, and the Plan does not cover cosmetic surgeries. Accordingly, the following procedures, which, under the 1990-2016 claims processing rules described above, are considered cosmetic procedures, are not covered: shoulder shaping, chin contouring and implants, face lifts (unless as a

medically necessary part of other facial procedures), facial bone osteoplasty, forehead reduction and contouring, mandible reduction, mandible contouring or mandible augmentation, and chondrolaryngoplasty (tracheal shave).

26. BCBSNC does not process claims for the vast majority of pharmaceuticals or hormones, although it does process claims for the administration of some pharmaceuticals, e.g. intravenous infusions.

27. BCBSNC has never implemented the portion of the Plan's benefit booklets that excludes "surgery for psychological or emotion reasons." More specifically, BCBSNC does not have diagnostic codes or procedural codes connected to this language from the Plan's benefits book that would prevent any claim from being approved, without regard to whether the Plan participant identified as cisgender, transgender, gender non-binary, or otherwise.

28. BCBSNC processes all claims for behavioral health treatment to be potentially reimbursed by the Plan. For behavioral health treatment, healthcare provider payment requests are not screened by diagnosis. Rather, notwithstanding the language contained in the Plan's benefits book, BCBSNC authorizes payment for all behavioral health services, if they are otherwise within the Plan's benefits, regardless of the submitted diagnosis code. This has been true since at least 1990. BCBSNC claims processing does not distinguish between an individual diagnosed with gender dysphoria or another psychiatric diagnosis. Plan participants with claims for behavioral health treatment are not denied because the submitted claim identified gender dysphoria as the diagnosis.

29. BCBSNC, as TPA of the State Health Plan does not code or track whether Plan participants identify as transgender, cisgender, gender non-binary, or otherwise, and BCBSNC's implements the benefit booklets of the State Health Plan without denying coverage for any healthcare service on the basis of a Plan participant's identification as transgender, cisgender, gender non-binary, or otherwise.

I declare and verify under penalty of perjury that the foregoing is true and correct. Executed on November 30, 2021.

Aimee Forehand (Nov 30, 2021 12:14 EST)

Aimee Forehand
Director, State Health Plan
Blue Cross and Blue Shield of North Carolina

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24 A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND TRICARE PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or TRICARE participation cases, the physician agrees to accept the charge determination of the Medicare carrier or TRICARE fiscal intermediary as the full charge and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or TRICARE fiscal intermediary if this is less than the charge submitted. TRICARE is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, TRICARE, FECA AND BLACK LUNG)

In submitting this claim for payment from federal funds, I certify that: 1) the information on this form is true, accurate and complete, 2) I have familiarized myself with all applicable laws, regulations, and program instructions, which are available from the Medicare contractor; 3) I have provided or will provide sufficient information required to allow the government to make an informed eligibility and payment decision; 4) this claim, whether submitted by me or on my behalf by my designated billing company, complies with all applicable Medicare and/or Medicaid laws, regulations, and program instructions for payment including but not limited to the Federal anti-kickback statute and Physician Self-Referral law (commonly known as Stark law), 5) the services on this form were medically necessary and personally furnished by me or were furnished incident to my professional service by my employee under my direct supervision, except as otherwise expressly permitted by Medicare or TRICARE; 6) for each service rendered incident to my professional service, the identity (legal name and NPI license #, or SSN) of the primary individual rendering each service is reported in the designated section.For services to be considered "incident to" a physician's professional services: 1) they must be rendered under the physician's direct supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of non-physicians must be included on the physician's bills.

For TRICARE claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, TRICARE, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, TRICARE and OWCP to ask you for information needed in the administration of the Medicare, TRICARE, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101,41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR TRICARE CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under TRICARE/CHAMPVA, to the Dept. of Justice for representation of the Secretary of Defense in civil actions, to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third party liability, coordination of benefits, and civil and criminal litigation related to the operation of TRICARE.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1197. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. This address is for comments and/or suggestions only. DO NOT MAIL COMPLETED CLAIM FORMS TO THIS ADDRESS.

1	2	3a PAT. CNTL #	4 TYPE OF BILL
		b. MED. REC. #	
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM / THROUGH	7

8 PATIENT NAME	a	9 PATIENT ADDRESS	a
b		b	c / d / e

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	22	23	24	25	26	27	28	29 ACDT STATE	30

	31 OCCURRENCE CODE	31 OCCURRENCE DATE	32 OCCURRENCE CODE	32 OCCURRENCE DATE	33 OCCURRENCE CODE	33 OCCURRENCE DATE	34 OCCURRENCE CODE	34 OCCURRENCE DATE	35 OCCURRENCE SPAN CODE	35 OCCURRENCE SPAN FROM	35 OCCURRENCE SPAN THROUGH	36 OCCURRENCE SPAN CODE	36 OCCURRENCE SPAN FROM	36 OCCURRENCE SPAN THROUGH	37	
a																a
b																b

38		39 VALUE CODES CODE	39 VALUE CODES AMOUNT	40 VALUE CODES CODE	40 VALUE CODES AMOUNT	41 VALUE CODES CODE	41 VALUE CODES AMOUNT
	a						
	b						
	c						
	d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1									1
2									2
3									3
4									4
5									5
6									6
7									7
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22									22
23		***PAGE ____ OF ____***	***CREATION DATE***		**TOTALS**				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI	
A							57	A
B							OTHER	B
C							PRV ID	C

	58 INSURED'S NAME	59 P REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A				A
B				B
C				C

66 DX	67	A	B	C	D	E	F	G	H	68
	I	J	K	L	M	N	O	P	Q	

69 ADMIT DX		70 PATIENT REASON DX	a	b	c	71 PPS CODE		72 ECI	a	b	c	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

76 ATTENDING	NPI	QUAL	
LAST		FIRST	
77 OPERATING	NPI	QUAL	
LAST		FIRST	
78 OTHER	NPI	QUAL	
LAST		FIRST	
79 OTHER	NPI	QUAL	
LAST		FIRST	

80 REMARKS	81CC		
	a		
	b		
	c		
	d		

UB-04 NOTICE: **THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARTY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).**

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
   (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
   (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
   (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
   (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
   (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
   (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
   (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
   (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

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